

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295077		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/16/2007	
NAME OF PROVIDER OR SUPPLIER REGENT CARE CENTER OF RENO				STREET ADDRESS, CITY, STATE, ZIP CODE 555 HAMMILL LANE RENO, NV 89511			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 22047 This Statement of Deficiencies was generated as the result of a complaint investigation conducted regarding your facility on 7/16/07.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p> <p>Complaint #NV00015318 alleged that the facility failed to:</p> <ol style="list-style-type: none"> 1. Document that the resident fell and that there was no record of the resident being seen by a physician. Unsubstantiated. 2. Stop giving the resident discontinued medications. Unsubstantiated. 3. Provide a safe environment around the dining room entrance during meal times due to congestion of residents. Unsubstantiated. 4. Keep residents billing source private by posting the information on the outside of the charts. Substantiated with no federal deficiencies cited. 5. Allow the complainant to go back and see the resident. Unsubstantiated. 6. Invite the complainant to a care conference upon the resident's discharge. Unsubstantiated. <p>No federal deficiencies were cited.</p>			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.